Hospital Coverage Under Medicare

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While Medicare appears to afford generous coverage for hospital care, statutory limitations and changes in medical practice often make access to coverage problematic.

Hospital Coverage

Medicare appears to afford generous benefits for hospital care. It will pay for the majority of the costs of inpatient hospital care so long as it is medically necessary for treatment or diagnosis. For nonpsychiatric hospitalizations, beneficiaries are eligible for up to 90 days of benefits for each “spell of illness,” with 60 additional days per lifetime (known as “lifetime reserve days”) available to each beneficiary. For psychiatric hospitalizations, benefits are limited to 190 days per lifetime. In practice, however, beneficiaries may encounter attempts to deny them admission to the hospital or to terminate Medicare coverage before they are ready to leave the hospital.

Medicare beneficiaries admitted for inpatient hospital care are responsible for a deductible amount per spell of illness and a coinsurance amount for days 61 through 150. The deductible and coinsurance amounts are subject to change annually. Most Medicare beneficiaries maintain private Medicare supplement (Medigap) insurance that covers all or part of the Medicare coinsurance and deductible amounts. Certain “luxury” items such as private rooms, private-duty nurses, television, and telephone are not covered by Medicare. Medicare’s definition of a “spell of illness” significantly limits coverage. A spell of illness ends and a new spell of illness begins 60 days after the patient is no longer receiving any inpatient hospital services or skilled

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nursing services in a skilled nursing facility. For example, a patient who is hospitalized for 90 days, enters a skilled nursing facility, and is then rehospitalized would not be entitled to any additional hospital coverage. A different result would occur if the patient was hospitalized for 150 days, discharged for 62 days, and then rehospitalized. In that case, the first spell of illness would have ended and a second spell of illness with a new round of coverage would be triggered by the second hospitalization.8

In addition to covering inpatient hospitalization, continuing coverage under Medicare's hospital benefit is available to patients who no longer need hospital care but who do require skilled care in a nursing facility if there are no beds available in a Medicare-certified skilled nursing facility.9 This coverage will end if the beneficiary fails to accept the first available bed in a Medicare-certified skilled nursing facility or when the need for daily, skilled nursing facility level of care ceases.10 A Medicare-covered hospital stay is also a prerequisite for any coverage for a subsequent nursing facility stay. Without an inpatient hospital stay lasting three days, not counting the day of discharge, there is no Medicare coverage for nursing home care.11

**Coverage Denials and Terminations**

There are several problems regarding hospital benefits that may be challenged through the Medicare appeal process: (1) “medical necessity” denials—either the initial denial of Medicare coverage when the patient seeks admission (an admission denial) or the termination of Medicare coverage subsequent to a Medicare-approved admission (a continued-stay denial); (2) the attempt to discharge the patient who needs skilled nursing facility care in the absence of an appropriate nursing home placement; and (3) the attempt to discharge without proper notice. A significant hurdle for most patients is that they become personally liable for the costs of care as soon as Medicare disavows coverage. With very limited exceptions,12 an appeal can only be filed when the patient decides to enter the hospital or to continue to stay there after being notified that Medicare will not pay for care.

**Medical Necessity Cases**

Hospital coverage is often denied based on a judgment that the patient did not initially require treatment or diagnostic services that could only be safely and effectively rendered in an inpatient hospital setting. For example, the hospital or Medicare may take the position that the patient could have been cared for through outpatient services or at a skilled nursing facility, or that a surgical procedure could have been safely performed at an ambulatory surgical center.

Even where coverage is initially granted upon admission, Medicare coverage will usually be terminated as soon as, in the hospital’s view, the patient’s condition has improved to the extent that further care, treatment, or diagnostic testing could be provided in an alternative setting.13 The major incentive encouraging quick discharges is the diagnostic-related group (DRG) system for hospital reimbursement used by Medicare. The DRG system establishes a set price that a hospital will be paid based on the admitting diagnosis, regardless of the length of the actual hospital stay. Once the hospital announces that coverage is terminated, the patient is faced with the choice of leaving or staying and paying the hospital’s private-pay rate. A recurrent problem is that patients are terminated from coverage before they are well enough to leave the hospital.

For both admission- and continued-stay-related denials, Medicare benefits can be won through the appeals process if it can be shown that the services required by the particular patient necessitate care, treatment, or diagnostic testing in a hospital setting.

The courts, in reviewing Medicare cases involving questions of medical necessity, have established two standards. First, the courts have consistently ruled that the patient’s total condition at the time the hospitalization occurred and during the stay must be considered. Under these decisions, both actual and potential needs for care and diagnostic services that prompted inpatient care must be taken into account, not just the care and services actually provided. Absent medical certainty that the patient’s condition was stable, and that there was no significant risk in denying admission or discharging the patient, coverage must be afforded. Second, the courts have ruled that hospital coverage must be afforded
whenever a hospital has provided any of the services listed in Title 42 of the United States Code (U.S.C.) Section 1395x(b), unless this care was purely custodial in nature or was not medically reasonable and necessary.

_Sowell v. Richardson_ is the seminal decision as to the rule that the patient's total condition must be considered and that reasoned, contemporaneous judgment as to the needs and potential needs for care must not be nullified based on the perfect vision of hindsight. The plaintiff, a 72-year-old cancer patient with diabetes and emphysema, was hospitalized for six days with shortness of breath, swelling in one leg, and inability to walk or care for herself. Care in the hospital consisted of diagnostic testing, oral medications, and a diabetic diet. The shortness of breath that precipitated the admission did not abate in the hospital and she was discharged to a nursing facility in the same condition as when she was admitted to the hospital. The court awarded Medicare coverage, noting that the perceived need for care at the time of admission determines coverage:

The legislation which created health insurance for the aged is remedial and therefore to be construed liberally to effectuate the congressional purpose. The purpose of the Act was to insure that adequate medical care was available to the elderly throughout this country. Neither the courts nor the Secretary should, in the interest of minimizing costs, so interpret the provisions of the Act as to frustrate its purpose. A sensible nontechnical approach to interpretation of this chapter is necessary in order to give effect to the purpose of the Act and to afford equitable treatment to those seeking its benefits.

The position taken by the Secretary is not in accord with these principles. Under his formula for determining whether the services are covered only the service actually rendered is considered. The condition of the insured and manifest symptoms of the illness are in his view only relevant to the extent that they determine the treatment administered. Were the law as contended by the Secretary, consideration of the trees is commanded but even a glimpse of the forest is prohibited. It was never intended by Congress that the condition of the insured, treatment that might at any time be necessary, and the pain and discomfort attending inadequate or unprofessional care or lack of care not be considered together with the treatment actually provided in determining whether extended care services are justified. Every aspect of the plaintiff's physical condition must be considered in making the determination. Treatments immediately required are of course a major factor. However, even if no treatment were required the condition of the insured might be so unstable or unsatisfactory, as to require the extended services contemplated by the statute.

Other cases have expanded this rationale. In _Studer v. Weinberger_, the court stated:

[T]he [Medicare Appeals] Council noted only that the claimant was assisted in moving and meeting her activities of daily living and that she was given oral medications that did not require hospitalization... But the Council... gave no consideration to those services that might have been needed and for which the claimant's stay was, for the most part, required. That is, even though her stay was "uneventful," her care was not necessarily custodial... Even if all the services actually provided were "custodial in nature," a patient could still be required to remain in hospital because of potential complications and that stay would be covered by the Act... The undisputed evidence indicated that the plaintiff required the availability of the medical facilities of a hospital.

In _Duncan v. Weinberger_, involving an 81-year-old man hospitalized for stroke-related left-side paralysis, the court ruled:

_Consideration must be given to items and services that may be required by the patient and... coverage may not be denied simply by considering only those treatments and services actually supplied... It is the quality of the care and the possible consequences of the lack of required services and not merely the quantity of the care that is crucial in determining whether the patient required the level of care contemplated by the Act as being covered._

A second line of cases established that once it is determined...
that the care provided was medically reasonable and necessary and that this care was not custodial in nature, then coverage should be awarded for hospital care so long as the care rendered includes any of the skilled services listed in 42 U.S.C. Section 1395x(b). In Kavanagh v. Bowen, the court stated:

[A]bsent a statutory exclusion, physical therapy constitutes inpatient hospital services covered by Medicare. . . [T]he Secretary, in ruling that a hospital patient must be acutely ill in order to qualify for Medicare coverage, and that Medicare will not reimburse the cost of skilled hospital care that could have been provided in a less skilled facility, applied an erroneous interpretation of the Social Security Act. . . [T]he proper standard under the Act is the level of care received and whether, given the patient's condition, it was reasonable and necessary. . . . [A]s long as the treatment received was reasonable and necessary, the location of the treatment is irrelevant to Medicare coverage. . . . The record indicates that the rehabilitation services that [the patient] received were skilled as that term is defined in the relevant regulation. 42 C.F.R. § 409.33(c) . . . [and] were also "inpatient services" as defined in subparagraph (3) of 42 U.S.C. § 1395x(b).23

Hultzman v. Weinberger24 involved hospitalization necessary for diagnostic services and physical and occupational therapy. The court held that medically necessary, noncustodial services trigger Medicare coverage for hospital care. Section 1395y(a)(1) excludes from coverage only those services that are not reasonable and necessary to the treatment or diagnosis of a patient's ailments. It does not speak at all to the question of whether it is medically necessary to provide such services on an inpatient or outpatient basis or in a hospital rather than an extended care facility.25

In Holladay v. Weinberger, the court reversed the decision of the Secretary denying Medicare coverage to the plaintiff, who had been treated in a hospital for osteoarthritis, acute hemochromatosis, anemia, chronic bronchitis, and bronchial asthma. The court concluded that

[Section] 1395y(a) does not draw any distinction based on the type of facility at which treatment may be provided. The section only excludes from Medicare coverage those inpatient hospital services not reasonable or necessary to treatment or diagnosis of the claimant's condition. If inpatient hospital services are medically necessary and not custodial in character, nothing in the plain language of 1395y(a) would forbid payment altogether simply because those services might have been rendered in an extended care facility. . . . Congress could not have intended to deny payment to qualified individuals for essential medical treatment solely because, without fault of the claimant, that treatment was rendered at an acute hospital rather than an extended care facility.27

Denials While Awaiting Nursing Facility Placement

Hospital coverage may be improperly denied to the patient who should be transferred to a skilled nursing facility (SNF). As noted above, Medicare law provides for continued hospital care if the patient requires SNF care and no appropriate SNF facility bed is available.28 Because of the financial pressure to discharge patients, this requirement is often ignored by hospital staff and the Medicare system. Given the difficulties patients may face in securing an SNF bed following hospitalization, this is an area where appeals are often appropriate. Financial difficulties, including problems relating to securing eligibility for Medicaid (Title 19), are not valid reasons for denying Medicare coverage. Similarly, there is no legal basis to deny extended hospital coverage when the patient is denied SNF placement due to the illegal or improper actions of an SNF or if a bed is not made available to the incompetent individual because the SNF requires written authorization of a conservator and no conservator has been appointed. The sole issue is whether placement in an appropriate Medicare-certified SNF was available to the patient. The primary burden of locating an SNF bed is placed on the discharge planner.29 Patients and their families need only cooperate with the efforts of the hospital discharge planning staff to secure an SNF bed in a facility that can provide the requisite level of care and that is reasonably close to the patient's place of residence or other family members.
While the statute creating extended coverage for those awaiting SNF placement permits the Secretary to establish criteria for determining when SNF "care services are not otherwise available to the individual," the Secretary's regulations contain very little guidance. Only Title 42 of the Code of Federal Regulations, Section 412.80, contains any narrowing of the "availability" standard. It limits the scope of review to a determination as to whether "a SNF bed is not available in the area." The applicable "area" is not otherwise specified by the regulations.

The court decisions that have spoken to this issue have followed this standard. In *Hurley v. Bowen*, the court of appeals determined that there are only two questions that need to be considered: Did the patient require at least an SNF level of care? If so, was the search for an SNF bed unsuccessful? The court held "that because there is no evidence that a SNF bed was available to Hurley, there is no basis for the secretary to deny payment to him." Based on this decision, a denial of benefits would only be justified where there is specific evidence that an SNF bed was available to the patient in question.

In *Monmouth Medical Center v. Harris*, the Third Circuit Court of Appeals concluded that the reason for the lack of availability of an SNF bed, such as a shortage of beds, and admission denials relating to the award of Medicaid coverage were not relevant in determining whether to grant or deny coverage. As indicated in *Monmouth*, Congress and the Secretary have assigned responsibility for seeking and securing an SNF bed to the medical personnel involved: the hospital discharge planning staff and the patient's attending doctor.

**Failure to Provide Notice of Noncoverage**

Medicare appeals should also be pursued when the hospital has failed to provide proper notice of denial or termination of Medicare coverage. The presumption is that all inpatient hospital care is Medicare-covered unless the patient receives written notice to the contrary. The hospital's utilization review committee makes the initial decision whether to grant, deny, or terminate Medicare coverage. It is required to issue a written notice of noncoverage to the patient, or the patient's representative, which details the basis for the noncoverage, explains that the patient will be financially liable for continued hospital care, and describes the patient's appeal rights. The patient may not be charged for the care absent receipt of advanced written notice of the denial or discontinuation of Medicare coverage, including notice of the right to appeal.

**Medicare Appeals in Hospital Cases**

Hospital appeals are initially processed by a Peer Review Organization (PRO), an organization that contracts with the Health Care Financing Administration to review quality-of-care issues relating to hospitals and to issue determinations in the first two levels of the Medicare appeal process. Appeals of the initial notification of noncoverage by the hospital are appealed to the PRO by a request for review.

Unlike other areas of Medicare law, it is possible to obtain an expedited review of the initial coverage denial, limited to cases involving the termination of Medicare coverage for hospital stays that were initially approved for coverage. Beneficiaries are entitled to two days' advance written notice from the hospital before Medicare coverage is terminated. If an appeal is initiated during that brief period, the patient cannot be charged for the cost of care until a decision is issued by the PRO.

Since hospitals may expect patients to leave when they are orally advised that coverage is terminated or that they will be discharged, requesting written notice and requesting review promptly may yield several extra days of hospital care at no cost to the patient.

In all hospital cases, appeals from the PRO review decision can be taken. Subsequent appeals include a request for reconsideration through the PRO, a hearing before a Social Security Administration administrative law judge, an appeal to the Medicare Appeals Council, and finally an appeal to the federal courts. The appeal process for inpatient hospital appeals is set forth in Title 42 of the Code of Federal Regulations (C.F.R.), Part 473, though this should also be read in conjunction with the regulations governing Medicare appeals generally: 42 C.F.R. section 405.701, *et seq.*, and 20 C.F.R. Part 404. Appeals to an administrative law judge-level
require at least $200 in controversy. Appeals to the federal courts are authorized when $2,000 or more is in dispute.

There is a somewhat different appeals process if the patient is enrolled in a Medicare managed care organization under Medicare Part C. See 42 C.F.R. Part 422. We will discuss Medicare managed care and appeals in future columns.

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Endnotes

1. 42 U.S.C § 1395x(b); 42 C.F.R. § 409.10 et seq.
5. 42 U.S.C. § 1395e(a)(1); 42 C.F.R. § 409.82. The deductible amount for 2000 is $776.
6. 42 U.S.C. § 1395(e)(a)(1)(A) and (B); 42 C.F.R. § 409.83. For 1999, the coinsurance amount for days 60-90 is $194 per day, and for days 91-150 it is $388 per day.
7. 42 U.S.C. § 1395x(a); 42 C.F.R. § 409.60.
8. See Mayburg v. Secretary of H.H.S., 740 F.2d 100 (1st Cir. 1984); see Levi v. Heckler, 736 F.2d 848 (2d Cir. 1984).
11. 42 C.F.R. § 409.30(a)(1).
12. For denials of coverage for continuing hospitalization, as opposed to a denial issued upon admission, beneficiaries are entitled to two days' advance notice from the hospital of the termination of Medicare coverage. A beneficiary may not be charged for care during that two-day period. If the beneficiary requests review promptly at this stage, financial liability is waived until there is a decision by the Peer Review Organization. 42 C.F.R. § 412.42(c); 42 C.F.R., pt. 466.
13. 42 C.F.R. § 412.24(c) and (d).
14. 42 U.S.C. § 1395x(b) provides:

The term "inpatient hospital services" means the following items and services furnished to an inpatient of a hospital (except as provided in paragraph (3)) by the hospital—

(1) bed and board;
(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and (3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements.
16. Id. at 693.
17. Id. at 691–92.
19. Id. at 9854-5 (emphasis in the original).
20. MEDICARE AND MEDICAID GUIDE (CCH) ¶ 27,060 (W.D.Va. 1974).
23. Id. at 362–63.
24. 495 F.2d 1276 (3d Cir. 1974).
25. Id. at 1282.


31. See 857 F.2d 907 (2d Cir. 1988).

32. Id. at 913.

33. See also Hayner v. Weinberger, 382 F. Supp. 762 (E.D.N.Y. 1974).

34. See 646 F.2d 74 (3d Cir. 1981).

35. 42 U.S.C. § 1395x(ee).

36. 42 C.F.R. § 424.13(b)(2).

37. 42 C.F.R. §§ 411.404(b), 412.42(c), 466.94(a)(1).


40. 42 C.F.R. § 412.42(c); 42 C.F.R. pt. 466.

41. 42 C.F.R. § 473.40.

42. 42 C.F.R. § 473.46.